TESTIMONY OF
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ON
HELPING THOSE WHO NEED IT MOST:
LOW-INCOME SENIORS AND THE NEW MEDICARE LAW
BEFORE THE
SENATE COMMITTEE ON AGING

JULY 19, 2004

Chairman Craig, Senator Breaux, distinguished members of the Committee, I thank you for inviting me here this afternoon to discuss the new Medicare prescription drug benefit created by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). As you are well aware, with passage of the MMA, Congress took substantial steps in updating the Medicare system to reflect modern medical practice. For the first time, Medicare beneficiaries will be able to obtain significant assistance with the costs of outpatient prescription drugs. In addition, these same beneficiaries will be using their market clout to drive prices down so that the dollars spent by them and by the government on their behalf will be able to provide more medications than before. We at the Centers for Medicare & Medicaid Services (CMS) are particularly excited about the substantial assistance available to low-income beneficiaries under this new program.

Early Success

The Medicare-approved prescription drug discount cards, which became available one and a half months ago, are already providing substantially lower drug prices for almost four million individuals, almost a million of whom have low–incomes and qualify for literally thousands of dollars in additional assistance from the $600 credit this year and next, and from "wraparound"

deep discounts from eight major drug manufacturers if they use up their credit. About 25,000 additional beneficiaries are signing up every business day. CMS' analyses have shown that the cards generate savings on brand name drugs of between 11 and 18 percent from the average price paid by all Americans, even those with health insurance. This same study showed steeper discounts off of generic drugs, in the range of 35 to 65 percent from what is paid, on average, for prescription drugs by all Americans.

Savings for low-income beneficiaries are even more significant. The CMS' analysis found that low-income beneficiaries can save 32 to 86 percent over national average retail prices over a 7-month period, when both the discounts and $600 transitional assistance are taken into account. The analysis further found that Medicare beneficiaries do not have to choose the Medicare-approved drug discount card with the very best price to realize substantial savings. Low-income beneficiaries choosing the Medicare-approved card with the 10th best price, rather than the best price, could still save 28 to 72 percent over a 7-month period, when both the discounts offered and $600 are taken into account. Low-income beneficiaries enrolling in Medicare-approved drug discount cards also benefit from having the enrollment fee paid by Medicare; free (plus a dispensing fee) or low, flat-fee, prices ($12 or $15) on many commonly-used brand name drugs like Lipitor or Zocor when the $600 is exhausted; and, coordination between Medicare-approved drug discount cards and state low-income programs to make sure beneficiaries are enrolled to the extent possible.

To give a concrete example of how these savings are working, consider Mr. Vincent Casisi, who lives in Kansas City, Missouri. Prior to receiving his drug card and transitional assistance, Mr.

Casisi had monthly drug costs of $343 for the five medications he takes. Had the MMA not passed, he would be paying $6,174 over the next eighteen months for those drugs. With the savings generated by his card and the private program available through Pfizer, his monthly expenses will drop to $163. The additional $1,200 in transitional assistance lowers his expenses further, so that his total drug costs for the 18 months go from $6,174 to $1,734 for a savings of $4,440.

Ms. Claudine Jones, of Wynne, Arkansas, has used her card to purchase refills of the six medications she takes. Normally, these medications cost her about $100. The discounts available through her card lowered the cost to $66, a 34 percent reduction. When the transitional assistance she qualified for was added to the bill, her total costs dropped to $6.58, a 93 percent savings. Ms. Jones, who said she about fell over when she heard the final cost, had a credit card ready to pay her bill, but she was able to pay cash instead.

Outreach to Beneficiaries

The findings from CMS' studies and the relief obtained by real people like Mr. Casisi and Ms. Jones, underscore the importance of outreach to Medicare beneficiaries, particularly those with low incomes, to ensure that the maximum number of eligible beneficiaries follow the simple steps to enroll in a Medicare-approved drug discount card.

Enrollment in the drug card is a simple process. As we have emphasized in our educational materials provided to beneficiaries, as well as in materials to those who counsel beneficiaries, help is available 24 hours a day, 7 days a week by calling 1-800-MEDICARE. When

beneficiaries call, they just need to know their zip code and information on the drugs they take. If they think their level of income qualifies them for the $600 annual credit, they can provide that information as well. Beneficiaries can also get information on the subset of cards that most interest them. For example, they can tell the representative at 1-800-MEDICARE preferences they may have, such as their preferred pharmacy or whether they are interested in low-cost or no-cost cards.

We will continue to work to provide beneficiaries accurate and easy-to-understand information about the Medicare-approved drug discount cards. Indeed, on May 27, we announced that we were making $4.6 million available to assist community-based organizations inform and enroll seniors who qualify for the $600 annual credit, including working with the Access to Benefits Coalition, a group of over 75 diverse, national non-profit organizations, all of which are committed to helping low-income Medicare beneficiaries find significant savings on their prescription drugs. These organizations have extensive experience and credibility with the low-income beneficiary population. The CMS believes that this additional outreach will produce real results in terms of getting the benefit to seniors who are most in need.

In addition, HHS has called for applications from community-based organizations to help low-income beneficiaries learn about the Medicare-approved drug discount card and how to enroll. HHS will award up to $15,000 to grassroots organizations for innovative programs that will best reach people where they live. Community organizations that band together to reach these seniors and people with a disability could receive as much as $50,000. These contracts are in addition to the $21 million previously made available to the State Health Insurance Assistance Programs

(SHIPs), which provide one-on-one assistance to Medicare beneficiaries through trained volunteer counselors who are provided training from CMS. Furthermore, HHS' Administration on Aging (AoA) and Indian Health Service (IHS) are reaching out to their constituencies to encourage beneficiaries to sign up for the program.

I might note that CMS has already begun the process of informing beneficiaries about the formal drug benefit to be made available in 2006. On July 7, Secretary Thompson announced $125 million in grants to states to help educate low-income Medicare beneficiaries who currently get their prescription drugs through State Pharmaceutical Assistance Programs (SPAPs) about the new Medicare drug benefit coming in 2006.

The predetermined grant amounts, which are distributed to states based on the number of participants enrolled in each program, are to be used to educate SPAP participants about prescription drug coverage available under prescription drug plans or Medicare-Advantage prescription drug plans; provide technical assistance, phone support, and counseling in order to help SPAP participants select and enroll in Part D plans; and, support other activities that promote effective coordination of enrollment, coverage, and payment between SPAPs and prescription drug plans.

Website Enhancements

Now Medicare beneficiaries will find it even easier to choose the lowest priced Medicare-approved drug discount card that best fits their individual needs. The updated www.medicare.gov features an improvement to the Price Compare tool that lists the five lowest

priced Medicare-approved drug discount cards that fit each beneficiary's individual drug needs. In addition, beneficiaries now will be able to sign up for a drug card on the Internet. These changes will also help beneficiaries get the same information faster when they call 1-800-MEDICARE.

CMS is continuing to improve www.medicare.gov to make it more useful. In fact, there is a feedback button on each page of the web site so CMS can hear directly from users. Many of the enhancements were generated from suggestions and comments received from beneficiaries and their family members, individuals who work with older Americans, such as the State Health Insurance Assistance Programs, and health care providers. On the updated web site users will find:

- A "Top 5 – Best Choice" list of the five cards that offer the lowest aggregate prices for an individual's drugs;
- Added "enrollment information" buttons to provide easy-to-access, easy-to-use information on how to enroll. This includes online enrollment for 36 different cards;
- Significant improvements to the drug entry tool making it easier and quicker for users to enter their drug information;
- An improved display of drug pricing information making it easier for users to compare the price differences among brand and generic drugs;
- More easy-to-understand information about state pharmacy assistance programs;
- More details about manufacturer "wrap-around" programs that offer additional discounts for beneficiaries who qualify for the $600 credit;

- A new "special features" link that provides updated card sponsor information such as online enrollment availability and manufacturer "wrap-around" programs; and
- A new tool under "resources" allowing users to select their state and immediately see a listing of all drug card sponsors in their area.

Each of these enhancements will also make it easier and faster for callers to get information about drug cards by calling 1-800-MEDICARE. There are now 3,000 operators answering an average of 50,000 calls a day at 1-800-MEDICARE. Average wait time is less than 2 minutes, making it even faster for callers to reach a customer service representative. The Medicare customer service representatives answer questions about the drug card and walk callers through the information available at www.medicare.gov. Beneficiaries who call can also get the information they need in a personalized brochure mailed to them the next day. Then, signing up for a card requires only filling out a two-page form or calling the card sponsor's toll-free number.

In our efforts to take all possible steps to help low-income beneficiaries without good drug coverage take advantage of these large savings, we have looked into the possibility of auto-enrolling Medicare Savings Program beneficiaries into the drug discount card program. However, our autoenrollment options for this population are limited. The MMA (Section 1860D-31(f)(2)(A)) provides that a transitional assistance applicant must certify that the individual's income, family size, and alternative sources of drug coverage (if any) meet required criteria. By regulation, we permit the individual's authorized representative to step into the shoes of the applicant and make this attestation on the individual's behalf. Consequently, either the individual or his or her authorized representative must certify as to the accuracy of such

information. This authorized representative authority is what we have worked to enable any interested State Pharmacy Assistance Programs (SPAPs) to use to autoenroll their Medicare members in drug discount cards. However, most States do not have authorized representative status for their Medicare Savings Program beneficiaries.

While we work with states on autoenrollment, however, the Administration is also committed to ensuring that each eligible beneficiary has the opportunity to enroll in the drug card program that best meets his or her needs. We are supporting a number of outreach efforts to assist beneficiaries in enrolling in a drug card of their choice, including reaching out to community based organizations to work with them to educate and enroll low income people with Medicare in a Medicare approved drug card and in the $600 credit.

Finally, in our continuing efforts to facilitate enrollment for low-income beneficiaries, CMS plans to allow electronic enrollment (via the internet) for the drug card with Transitional Assistance. Internet based enrollment will be a big help in the outreach we are doing particularly with the community based organizations.

Further Relief: Self-Administered Drugs

On June 24 this year, CMS announced the inception of a new program, created under section 641 of the MMA. This program will provide coverage for up to 50,000 Medicare beneficiaries for self-administered drugs for cancer and certain other chronic conditions. Currently Medicare does not cover drugs that are usually self-administered. This program will begin enrolling beneficiaries in August and providing coverage as soon as September of this year. The program

will run through the end of 2005, when the full Medicare drug benefit will begin. Beneficiary cost-sharing for self-administered drugs covered under this program will be roughly equivalent to that which will apply to drugs covered under the new drug benefit beginning in 2006. Low-income beneficiaries are expected to realize significant savings. For example, those individuals with incomes below 135% FPL will be able to get very costly but potentially life-saving drugs like Gleevec and Tracleer for at most $60 per year, and in many cases even less – a savings of nearly 100 percent of the cost.

Prescription Drug Benefit and Subsidies

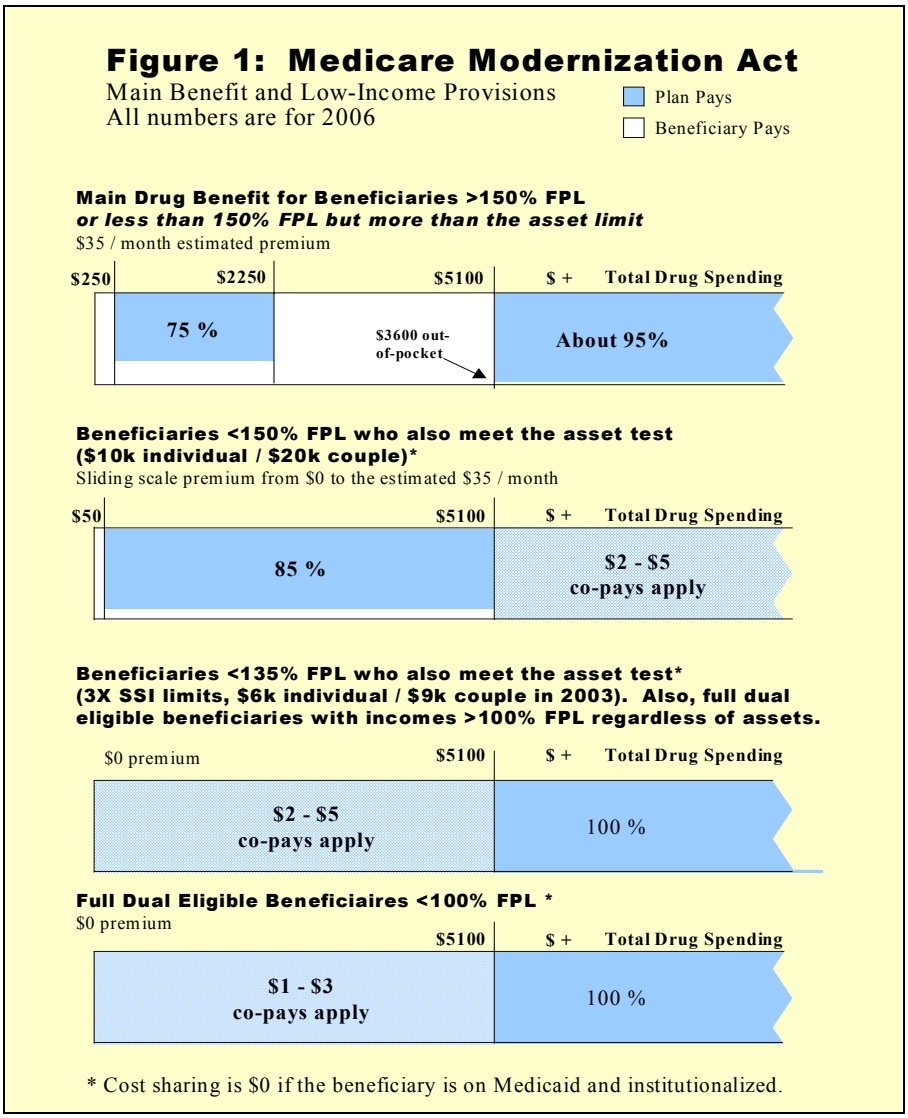
The drug card and the self-administered drug program, however, are only precursors to the full drug benefit that will become available to all Medicare beneficiaries, beginning in 2006. The new drug benefit has been targeted to provide the greatest assistance to seniors and people with disabilities who are most in need – people with very low incomes and people with very high drug costs. Dual eligible beneficiaries have the opportunity to enroll in a program of their choice, but to ensure that they receive the substantial benefits available to them, will be auto-enrolled if they are unable to do so in time to enjoy those benefits. Other beneficiaries will be able to voluntarily select a drug benefit that best meets their needs. Beneficiaries may stay with Medicare fee-for-service without drug coverage, as they have now, or they may select a drug plan to supplement fee-for-service coverage, or they may enroll in a Medicare Advantage plan that includes drug coverage. Beneficiaries choose the best plan for their individual needs.

Level of Assistance

Under the new drug benefit, full benefit dual eligible individuals – those qualifying for Medicare who also receive the full range of benefits under Medicaid - will receive drug coverage through Medicare. Full benefit dual eligible individuals will automatically qualify for low-income subsidies covering premiums and most cost sharing for the drug plan they select. State Medicaid programs will no longer provide prescription drug coverage for full benefit dual eligible individuals except, at state option, for certain drugs that Medicare will not cover. This change provides significant fiscal relief for states since states currently pay for prescription drugs for full benefit dual eligibles. These expenditures are substantial, amounting to nearly $7 billion in state spending in 2002. The law provides for a continued state contribution to the cost of providing prescription drug benefits to these individuals through a monthly payment from the states to the Federal government similar to the mechanism through which states pay Medicare Part B premiums on behalf of dual-eligible individuals. Dual eligible individuals -- including those in Medicare Savings Programs (QMBs, SLMBs and QIs) -- will automatically qualify for Federal low-income subsidies for drug plan premiums and cost-sharing.

Specifically, the three groups of low-income beneficiaries who will receive premium and cost-sharing subsidies include approximately 6.4 million full benefit dual eligible individuals; an estimated 3 million individuals with incomes lower than 135 percent of the Federal poverty level (FPL) ($12,569 for an individual and $16,862 for a couple in 2004) and assets up to $6,000, or $9,000 for a couple; and approximately 1.5 million Medicare beneficiaries with incomes at or over 135 percent but less than 150 percent FPL ($13,965 for an individual and $18,735 for a couple in 2004) who also meet the resource standard of $10,000 for an individual or $20,000 for

a couple in 2006. The chart below outlines the level of benefits for each group. Institutionalized persons who are full-benefit dual eligibles are exempt from cost sharing.



As can be seen from these figures, low-income beneficiaries - those who need it most - will receive substantial assistance under the new drug benefit. In addition to reductions in their costs,

low-income Medicare beneficiaries will have choices about where they want to apply for their new coverage. A streamlined process to determine eligibility for low-income subsidies will be available to beneficiaries.

Minority Populations and the MMA

While the provisions for low-income individuals will be important to all who qualify, they are especially important to the minority population who as a group tend to have greater needs than other groups have. The MMA provides over 7.8 million minority Medicare beneficiaries with access to a prescription drug benefit for the first time in the history of the Medicare program. The poorest minority beneficiaries – the nearly 2 million with incomes below 100 percent of FPL who are eligible for full benefits under Medicaid – will pay no premiums, no deductibles, and only nominal cost-sharing of $1 for a generic drug or a preferred multiple source drug and $3 for all other drugs. In addition, by moving out of their current Medicaid programs and into the new Medicare drug benefit, they will not be limited to any state imposed restrictions on the types or amounts of drugs they can receive.

The group of over 2.5 million low-income minority beneficiaries – all other seniors who are eligible for full benefits under Medicaid, as well as other seniors with incomes below 135 percent of FPL with assets of no more than $6,000 per individual and $9,000 per couple – will pay no premiums, no deductibles, and only nominal cost-sharing of $2 for a generic drug or a preferred multiple source drug and $5 for all other drugs.

An additional group of nearly 480,000 low-income minority beneficiaries – those with incomes below 150 percent of FPL and assets of no more than $10,000 per individual and $20,000 per couple – will get sliding scale subsidies for their premiums, and pay both a lower deductible and lower cost-sharing compared to the standard benefit.

The MMA stabilizes and helps expand the current Medicare+Choice program. Aged minority beneficiaries, particularly Hispanics, have enrolled in Medicare+Choice plans at a higher rate than the general Medicare population. That's because Medicare+Choice plans mean substantially lower out-of-pocket payments for beneficiaries who don't have access to generous supplemental "Medigap" coverage from their former employer, and have incomes too high to qualify for Medicaid. According to recent studies, these beneficiaries can save on average around $800 and (if they have significant illnesses leading to fair or poor health status) around $1900, compared to their total out-of-pocket payments in fee-for-service Medicare. The MMA renamed Medicare+Choice to Medicare Advantage and has already expanded the participation of private health plans in Medicare and (because the additional payments are passed on in better benefits and reduced cost sharing) has led to even greater beneficiary savings, and will ensure even greater access to integrated health plans to populations who have valued these plans the most.

Beginning in 2005, all newly enrolled Medicare beneficiaries will be covered for an initial physical examination. Minority Medicare beneficiaries, who are disproportionately at risk for cardiovascular disease and diabetes as compared to all Medicare beneficiaries, will benefit considerably by being able to take advantage of new preventive services, including

cardiovascular screening blood tests and diabetes screening to understand and improve their own health.

These new benefits can be used to screen minority beneficiaries for many illnesses and conditions that, if caught early, can be treated and managed, and can result in far fewer serious health consequences.

Disease Management, a service that exists in most integrated health plans, is being introduced into both the original Medicare program and PPO-style MA plans. These programs will provide beneficiaries the tools and support systems to help them manage their chronic illnesses and they are likely to substantially benefit minorities.

Which Drugs Are Covered?

Medicare prescription drug plans will cover drugs in every therapeutic class of FDA-approved drugs and biologicals, as well as insulin and supplies associated with its administration. Unlike current optional Medicaid coverage, Medicare drug plans may offer coverage for drugs that help people to stop smoking.

Medicare prescription drug plans will be able to set up selective formularies for their plans. These formularies may be closed, in which the plan only covers certain drugs, or open, in which all drugs are covered, but beneficiaries receive preferred drugs for lower co-pays than non-preferred drugs. Regardless of the formulary structure, the plans are required to include, when available, at least two drugs in every therapeutic category, unless the category includes only one

drug. Beneficiaries will know which drugs are on the formulary when selecting plans.

In establishing a formulary, the plan must have a pharmacy and therapeutic committee consisting of practicing doctors and pharmacists, including providers who have expertise in the treatment of seniors and the disabled. The U.S Pharmacopoeia, a nationally recognized clinically based independent organization, will develop, in consultation with other interested parties, a model guideline of therapeutic categories and classes. When choosing drugs for a formulary, a plan must also be mindful of the drug's specific therapeutic advantages. Plans will have an incentive to offer multiple drugs in a therapeutic class in order to attract enrollment. When approving plans, CMS will review all proposed formularies to ensure that they are not designed to discourage enrollment by people with certain types of medical conditions.

Furthermore, if beneficiaries find that the drug they need is not on their plan's formulary (or is on a non-preferred cost-sharing tier), an appeal is possible. A doctor would need to certify that the drugs on the formulary are not as effective as the desired drug or would adversely affect the beneficiary. If the appeal is successful, then the beneficiary can get the drug as though it were on the formulary (or preferred tier), and any cost-sharing amounts paid will count toward the out-of-pocket limit.

The MMA also allows state Medicaid programs to continue to provide the so-called excluded drugs, such as certain anti-anxiety drugs, weight loss and gain drugs, and over-the-counter drugs, and still be paid the regular matching amount by the Federal government.

Pharmacy Access

All prescription drug plans will be required to meet a strict pharmacy access standard in their service area to give beneficiaries convenient access to retail pharmacies. This standard ensures that, at a minimum, the pharmacy network is broad enough so that:

- 90 percent of urban enrollees live within 2 miles of a network pharmacy,
- 90 percent of suburban enrollees live within 5 miles, and
- 70 percent of rural beneficiaries live within 15 miles.

Help to States

According to a recent Office of Inspector General report, states have identified prescription drugs as the top Medicaid cost driver (FY 2002, Federal and state Medicaid prescription drug expenditures totaled approximately $29 billion with nearly $12.5 billion of that figure coming from the states. Prescription drug spending accounted for 12 percent of the Medicaid budget). From 1997 to 2001, Medicaid expenditures for prescription drugs grew at more than twice the rate of total Medicaid spending. These pressures on state budgets have led to coverage restrictions.

Some states currently contain Medicaid drug costs by limiting the number of prescriptions filled in a specified time period or limiting the frequency of dispensing a drug. Some states also limit the number of refills. In contrast, such policies will not be permitted under the new Medicare prescription drug benefit; thus most beneficiaries will have greater access and choice under the new drug benefit than they previously had under their state Medicaid program.

As I noted earlier, starting in 2006, full benefit dual eligibles will receive prescription drug coverage through the Federal Medicare program. Because states will no longer incur prescription drug costs for these beneficiaries, states will be required to make payments to the Federal government to defray a portion of the Medicare drug expenditures for full-benefit dual eligibles. Even after these payments and new enrollment of previously un-enrolled, but Medicaid-eligible beneficiaries, CMS estimates that states will realize a net savings of approximately $8.2 billion over five years.

In addition, the new drug benefit will permit state pharmacy assistance programs (SPAPs) to "wrap around" the comprehensive coverage for many beneficiaries. As a result, states can provide the same or better coverage for the beneficiaries currently covered through state programs.

States will also receive new assistance with the costs of drug coverage for their retirees, just like other large employers. Medicare intends to work closely with all states, through regulatory comment processes, the new "SPAP Commission," and many other forums, to ensure that the drug benefit provides better coverage and lower costs for beneficiaries.

How The Prescription Drug Benefit Works

Seniors will have two basic ways to receive the new drug benefits. First, they may choose to receive their full Medicare benefits (including hospital care, physician services, home health care, preventive services, and others) and the new voluntary prescription drug benefit through a "Medicare Advantage" plan. These plans may be preferred providers organizations (the most

popular choice among federal employees), health maintenance organizations, or other styles of private plans. Alternatively, seniors may enroll in CMS' original fee-for-service program, and choose to receive drug benefits through private drug plans that will be approved by CMS to provide the new prescription drug benefit. The plans will bid to provide drug coverage to seniors for a specific area of the country. These areas may be local, as is the case with Medicare+Choice plans today, but most bids are expected to include larger regions to be defined by CMS. The law requires that there be at least ten, and no more than fifty such regions. We are analyzing the information that we have available today to define regions that will provide the greatest opportunity for high quality and good value for our seniors.

Eligibility and Enrollment

All 41 million Medicare beneficiaries will have the choice of enrolling in the new Medicare drug benefit. Anyone entitled to Medicare Part A *or* enrolled in Part B is eligible to join. Joining will involve selecting an approved PDP or MA plan offering drug coverage, and enrolling in that plan for the year. While full dual eligible beneficiaries will be auto-enrolled after having the opportunity to select a plan themselves, enrollment for all other beneficiaries is entirely voluntary. However, beneficiaries who choose not to join at the first opportunity may face a late enrollment penalty if they later choose to enter the program. This penalty is similar to a penalty currently in place for late enrollment in Medicare Part B and is meant to make sure that people don't wait until they are sick to sign up, thus skewing the risk pool.

Beneficiaries who have other sources of drug coverage – through a former employer, for example – may stay in that plan and not enroll in one of the new drug plans under Medicare. If

their other coverage is at least as good as that offered under Medicare (and therefore considered "creditable coverage"), the beneficiary can avoid any late enrollment penalties when or if they lose that coverage and choose to enroll in a Medicare plan at some later date.

The new drug benefit has an "opt-in" rule. That means that, with limited exceptions, beneficiaries will need to make an affirmative statement to enroll in a prescription drug plan by filling out an enrollment form and joining an approved plan. This will be different from the "opt-out" rule that exists in Part B, where people are deemed to have enrolled in the program when they turn 65 unless they notify Medicare otherwise.

The statute allows people with Medicare to file for subsidy eligibility determinations with the Social Security Administration (SSA) or with the States. To be successful, these processes need to be as parallel as possible. To facilitate rapid and simplified enrollment of these individuals, CMS has worked closely with SSA to consider options to implement a consistent and timely system that accommodates the States and SSA.

SSA is developing a simplified application that will be scannable and able to be used via the Internet. State personnel assisting beneficiaries with the SSA application will be able to use the internet-based form. These applications would be processed through SSA and SSA would own the associated development/redetermination/appeals for applications submitted to SSA. CMS will also make the scannable forms and the Internet application available to State Health Insurance and Assistance Programs, community based organizations and other partners to assist people enrolling in the subsidy.

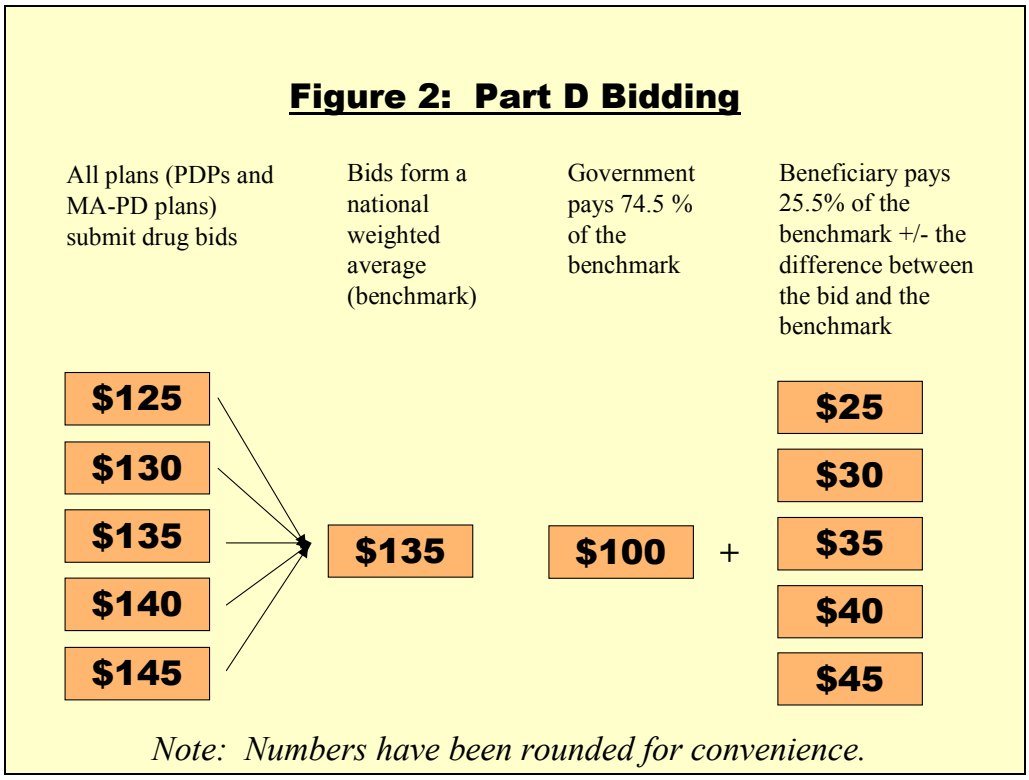
States may also take and process applications directly; however, we believe there will be significant economies for States in using the SSA application and associated processes. SSA and CMS have agreed that in order to make the drug subsidy available by January 1, 2006 there needs to be a pre-authorization process beginning in the summer of 2005.

The new prescription drug coverage begins on January 1, 2006. Initial open enrollment will begin November 15, 2005 and will run for six months to May 15, 2006. In later years, open enrollment will run from November 15 to December 31 for the next benefit year. The enrollment periods for PDP and MA plans will run concurrently.

Premium, Deductible and Cost Sharing

Beneficiaries who do not fall into one of several low-income categories, and therefore do not qualify for additional assistance available to these individuals, will be responsible for monthly premiums, annual deductibles and cost sharing up to a certain point.

Beneficiary premiums will be determined through a competitive bidding process. Premiums are expected to average about $35 dollars per month in 2006. Premiums will vary by plan and will be determined by the plans' bids. Beneficiaries may be able to save money by choosing a lower-priced plan, as illustrated below in Figure 2.



In the plan bidding sequence, all plans submit a bid for the cost of providing the drug benefit to a typical beneficiary in the service area. The typical beneficiary is a statistical average of age and health status for the nation.

CMS will then review the bids, and all approved bids will be compiled into a national weighted average. Premiums for a given plan will be set at 25.5 percent of the national weighted average plus or minus any difference between the national average and the plan's bid. This last point is important because plans whose bids are lower than the national average will end up charging their enrollees lower premiums, thus giving beneficiaries an incentive to sign up and increasing their market share. The competitive element among plans will give them motivation to drive the hardest bargains they can with drug manufacturers, in order to be able to underbid their competitors and thereby attract more customers. In each succeeding year, plans will compete

with each other. This competition will push prices down, just as it has in the prescription drug card program.

Three other factors will affect the premium that each beneficiary pays. First, as discussed earlier, if the beneficiary qualifies for low-income assistance, then the premium will be reduced on a sliding scale or eliminated entirely depending on the beneficiary's income. Second, if the beneficiary does not enroll in a drug plan at the first opportunity and does not maintain creditable coverage, than a late enrollment penalty may apply. Finally, if the beneficiary chooses a plan that features supplemental coverage over and above the standard D benefit, a supplemental premium may apply.

The standard benefit features a $250 annual deductible and 25 percent beneficiary cost sharing up to an initial coverage limit of $2,250. After that, catastrophic coverage begins once a beneficiary reaches $3,600 in out-of-pocket expenses ($5,100 in total drug spending). To be counted as out-of-pocket expenses, the beneficiary (or another individual, such as a family member) must actually be paying the costs. In general, the costs cannot be paid by another insurer and count toward the $3,600 limit, though contributions by state pharmacy assistance programs do count. In the catastrophic coverage range, the beneficiary pays the greater of 5 percent cost sharing or $2 and $5 co-pays. This catastrophic coverage is something that has not been available to most Medicare beneficiaries, even those with supplemental coverage, since the Medicare-approved Medigap plans did not allow such coverage.

Currently, Medicare beneficiaries without coverage pay full retail prices, the most expensive way to obtain drugs. With coverage under one of the Medicare prescription drug plans, beneficiaries will save in two ways – first through the direct coverage, and second when they pay for drugs out of their own pockets, they will be making purchases based on prices that are substantially reduced from what they otherwise would pay as a result of their plan's negotiated discounts with manufacturers. These discounts provide real value – so their dollars will go further. We have seen exactly this dynamic in the prescription drug discount card and are encouraged by its success.

Conclusion

The new prescription drug benefit will provide substantial new protections for Medicare beneficiaries, and particularly for those low-income beneficiaries who often struggle with the cost of prescription drugs. The Medicare prescription drug card provides low-income seniors with transitional assistance of $600 in 2004 and an additional $600 in 2005 for a total of $1,200. In addition, these seniors also benefit from the lower prices negotiated by the drug card sponsors. When implemented in 2006, the comprehensive prescription drug benefit will provide even greater coverage for low-income seniors. We look forward to keeping the Congress informed as we move toward implementation of this very important program. Thank you for your time, and I look forward to answering any questions you may have.